12.a. Prescribed drugs. (continued)

(2) The following categories of drugs subject to restriction under §1927(d)(2) are *not covered*:

(a) Agents when used for anorexia or weight gain, except that medically necessary anorectics are covered for recipients previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese.
(b) Agents when used to promote fertility.
(c) Agents when used for hair growth.
(d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
(e) Drugs described in §1703(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of 21 CFR §310.6(b)(1) (DESI drugs)).

Other categories of drugs listed under §1927(d)(2) are *covered with limitations*.

12.b. Dentures.

- Purchase or replacement of dentures is limited to one time every five years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified if a client is missing teeth necessary to fit or anchor the dentures.

- Replacement of dentures less than five years old requires prior authorization.

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

12.c. Prosthetic devices.

- Prosthetic or orthotic devices means replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or real function or to support a weak or deformed part of the body.

- Prosthetic or orthotic devices are eligible for payment with the following limitation:

  - Ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedic or physiatrics, or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

- The following prosthetic or orthotic devices and repairs are not eligible for payment:

  1) A device for which Medicare has denied the claim as not medically necessary;
  2) A device that is not medically necessary for the recipient;
  3) A device, other than a hearing aid, that is provided to a recipient who is an outpatient or resident of a long-term care facility and this is billed directly to medical assistance except as in item 7.c., Medical Supplies, Equipment and Appliances;
  4) Repair of a rented device;
  5) Repair of a device if the repair is covered by warranty;
  6) Routine, periodic service of a recipient's device owned by a long-term care facility;
  7) A device that has as a purpose to serve as a convenience to a person caring for the recipient;
  8) A device that is not received by the recipient; ~~and~~
  9) A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health; and
  10) A device not supplied by a medical supplier.

12.d. Eyeglasses.

- Comprehensive vision examinations and intermediate vision examinations are eligible for payment.

- Medically necessary eyeglasses are specifically defined.

- Eyeglasses which have been lost, stolen, or irreparably damaged must be an identical replacement.

- Payment will be made for a new pair of eyeglasses for:

  1) a change in the recipient's head size;
  2) a change in eyeglasses mandated by medical necessity; and
  3) for allergic reaction to the eyeglass material

- The following eyeglasses or eyeglass services are not covered:

  1) eyeglasses and lenses not covered by a contract obtained through the competitive bidding process;
  2) cosmetic services. Examples are: contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, marked acuity improvement over correction with eyeglasses, or bandage lenses;
  3) dispensing services related to a noncovered service;
  4) replacement of lenses or frames to change the style or color;
  5) fashion tints and polarized lenses, unless medically necessary;
  6) protective coating for plastic lenses;
  7) edge and anti-reflective coating of lenses;
  8) industrial or sport eyeglasses, unless they are the recipient's only pair and are necessary for vision correction;

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

- See Items 13.a. through 13.d.

13.a. Diagnostic services:

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.b. Screening services:

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.c. Preventive services:

- Preventive services are health services provided to a recipient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or to provide care for pregnancy.
- Services must be provided to the recipient on a face-to-face basis.
- The services must affect the recipient's care rather than the recipient's environment.
- The service must not be otherwise available to the recipient without cost as part of another program funded by a government or private agency.
- The service must not be part of another covered service.
- The service must be to avoid or minimize an illness, infection, or disability which will respond to treatment.
- The service must be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness, infection, or disability.
- Prior authorized cardiac rehabilitation services are covered preventive services with the following limitations:

  1) The services must be defined services whereby a physician is on the premises of the active program at all times in which the facility is opened.

  2) The services must be conducted in an area set aside for the exclusive use of the program while it is in session.

  3) The service must be a Medicare approved cardiac rehabilitation program.

13.c. Preventive services: (continued)

- The following services may be offered within the cardiac program as a covered service:

  1) diagnostic testing - stress testing;

  2) ECG monitoring;

  3) other reasonable and necessary diagnostic services;

  4) psychotherapy,

  5) exercise therapy.

- The following cardiac rehabilitation services are not eligible for payment:

  1) services provided without the direct on premises supervision of a physician;

  2) physical therapy and occupational therapy in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy;

  3) patient education.

- The following preventative services are not eligible for payment:

  1) service that is only for a vocational purpose or an educational purpose that is not health related; and

  2) service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

13.d. Rehabilitative services.

Rehabilitative services are limited to:

(1) Services provided under the recommendation of a physician. The therapeutic treatment must be a part of the recipient's plan of care; and

(2) Services that are medically necessary and the least expensive, appropriate alternative.

Coverage of **day treatment services for mental illness** is limited to:

(1) Services recommended by a psychiatrist, licensed psychologist, licensed independent clinical social worker, registered nurse with a master's degree and certificate from the American Nurses Association as a clinical specialist in psychiatric nursing or mental health; licensed psychological practitioner; or licensed marriage or family counselor in a community mental health center. Licensed marriage and family counselors are subject to the limitations in item 6.d.A.;

(2) Services supervised by an enrolled psychiatrist or other mental health professional listed in item 6.d.A.;

(3) Services provided in or by one of the following:

(A) Joint Commission on the Accreditation of Healthcare Organizations approved outpatient hospital;

(B) Community Mental Health Center;

(C) County contracted day treatment provider.

(4) Services provided up to 16 hours per week.